

<b>Case Number:</b>	CM15-0058131		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	04/23/2012
<b>Decision Date:</b>	05/26/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 24 year old male who sustained a work related injury April 23, 2014. According to a primary treating physician's progress report, dated March 11, 2015, the injured worker presented for a follow-up visit with 3-7/10 lumbar back pain, and right lower extremity radicular pain in the L5-S1 distribution. He is slightly more active but quits with any sign of increased pain. His weight is 311 pounds, sits on left buttock, shifting weight from right to avoid pain and radiculalgia. He walks with a cane but is not needed as gait without antalgia. Diagnoses are displacement of lumbar intervertebral disc without myelopathy(s/p decompression and epidural steroid injection); lumbar sprain/strain; thoracic/lumbar strain/sprain. Treatment plan included prescription for Oxycodone 10mg #60, one to two daily as needed.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Oxycodone 10mg Qty: 60.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 79.

**Decision rationale:** Oxycodone 10 mg # 60 is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances; (b) continuing pain with evidence of intolerable adverse effects; (c) decrease in functioning; (d) resolution of pain; (e) if serious non-adherence is occurring; (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of documentation of improved function with this opioid. In fact, the claimant was designated permanent and stationary; therefore, the requested medication is not medically necessary. It is more appropriate to wean the claimant of this medication to avoid side effects of withdrawal.